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ALCOHOL, OTHER DRUGS, AND OBESITY

PLAN-OF-THE-DAY NOTES

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VOL. II

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MEMORANDUM FOR ALL COMMANDERS, COMMANDING OFFICERS AND OFFICERS-IN-CHARGE

Subj: ALCOHOL, OTHER DRUGS, AND OBESITY PLAN-OF-THE-DAY NOTES, VOLUME II

Ref: (a) OPNAVINST 5350.4 Series

1. Reference (a) charges your command Drug and Alcohol Program Advisor (DAPA) to coordinate or assist in the presentation of alcohol and other drug abuse awareness education. An effective information program is essential to all prevention efforts. One element of that information program should include frequent publication of alcohol and other drug abuse material in the local news media, be it Plan-Of-The-Day (POD) or base/ship newspaper.

2. Alcohol, Other Drugs, and Obesity POD Notes (Volume I), was published and distributed in May 1992. Fleet feedback indicates it was a well-received, well-used edition. This publication, Volume II, is provided for you to pass to your DAPA to assist him or her in getting the message out. It is not meant to be all inclusive or restrictive. Many creative DAPA's are already doing a fine job of awareness education. This pamphlet is intended to be an aid to the over-burdened or collateral duty DAPA who just doesn't seem to have enough hours in the day to get everything done. It has been expanded to include more feature articles and artwork for posters/flyers. In addition, much of the information contained in Volume I is still current and relevant enough to be used.

3. If you or your DAPA would like extra copies of Volume II, have any questions about it, or would like to contribute more POD notes for a subsequent printing, please feel free to contact this office. Our address is: Bureau of Naval Personnel, Pers-63, Washington, DC 20370-5630. Our telephone numbers are: commercial, 703-614-8008 or DSN 224-8008.

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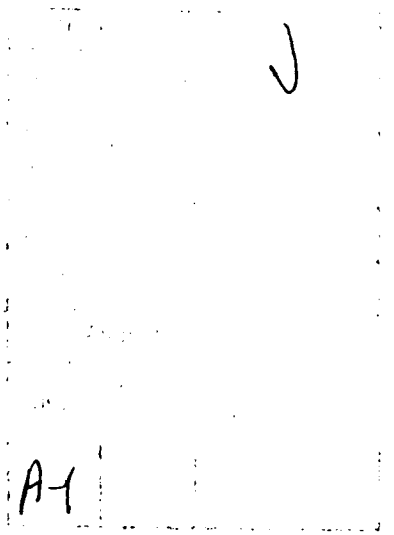
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NOTES



¡ N O T E S ¡

According to the Trauma Foundation, based at San Francisco General Hospital, there are approximately 23,830 alcohol-related trauma deaths annually, other than motor vehicle crashes. Heavy drinking doubles the risk of fatal injury, and studies indicate that alcohol is involved in 41% of deaths from unintentional falls, 47% of drownings and 33% of suicides. At a trauma center in Orange County, CA, 52% of the people injured in fights and 49% of those treated for stab wounds had positive BACs, and Maryland researchers studying 398 fatal fires found that 40% of the fire victims had positive blood alcohol concentrations.[1]

###

In recent studies done on rats, it was shown that alcohol increased cancer spread by suppressing the ability of "natural killer" cells to destroy cancer cells traveling in the blood-stream. The findings are particularly important for women because previous studies suggest women who drink as little as one to two drinks a day have an incidence of breast cancer anywhere from 10% to 100% higher than nondrinkers.[2]

###

According to the National Highway Traffic Safety Administration:[3]

- In 1990, traffic crashes killed 3,238 motorcyclists. An additional 72,000 were injured.

- In 1990, alcohol was present in 57.5% of motorcycle operations involved in fatal crashes. The presence of alcohol is higher in motorcycle operators involved in fatal traffic crashes than in the operators of any other type of vehicle in fatal crashes.

- In 1990, 30% of motorcycle drivers under the age of 20 killed in traffic crashes had some level of alcohol in their blood, with the majority of these having a blood alcohol content of .10% or above.

- Although motorcycles represent less than 3% of all registered motor vehicles, crashes involving motorcycles account for almost 7% of all motor vehicles fatalities.

- A study of all injured motorcyclists admitted to Maryland trauma centers for a one-year period in 1987-1988 found that of the 165 patient tests for alcohol use 53.3% tested positive. Of the riders under the legal drinking age tested for alcohol use, 31.3% tested positive.

###

In spite of the continuing downward trend in alcohol consumption, don't look for Seagram's, Gallo and Anheuser-Busch to abandon efforts to lure consumers to consume their products. In 1991 the alcohol industry spent $1.1 billion in measured media advertising, and another $500 million in sale promotions, point-of-purchase ads and other unmeasured media advertising. Alcoholic beverages are still big business in the U.S., with consumers spending a record $91.6 billion for beer, wine and distilled spirits in 1991.[4]

###

A report based on 1.6 million Pennsylvania Blue Cross members' claims said in-patient hospitalization for substance abuse treatment is four times greater for children of alcoholics than for others. Children of alcoholics' admission rates are higher, and once admitted, they have 61.7% more patient days than others. In addition, total health care charges for children of alcoholics is 32% greater.[5]

###

Nearly 7 out of 10 manslaughter offenses occur after a person has been drinking or using other drugs.[6]

###

Alcohol and other drugs will cost every man, woman and child in the nation more than $800 each this year, for a total of almost $200 billion in 1993. Approximately $90.4 billion in health care costs alone could be saved if alcohol and other drug problems were stopped before they started.[7]

###

In 1991, the U.S. Government spent $28 million of taxpayers' money to promote consumption of U.S. alcohol products overseas.[8]

###

Substance abuse is twice as prevalent in American men as in American women, according to federal statistics. Over 12% of men abuse or are dependent on alcohol, compared to 5% of women. And 3% of men abuse or are dependent on other drugs, compared to 1.5% of women. It is important to remember that drinking and other drug use frequently go together. Over 50% of women in treatment for alcoholism also use other drugs. The number one factor determining a woman's drinking or drug habits is her partner's drinking or drug habits.[9]

###

Alcohol and Sports[10]

- Among high school and college coaches, alcohol is cited overwhelmingly as the greatest drug problem for youth--even student athletes.

- In 1990, the NCAA restricted the number of beer commercials during NCAA telecasts.

- Of 28 major league ball parks, only three now sell beer the entire length of a game. Some have family sections where drinking alcohol is not permitted. In most parks there are no beer vendors in the stands, and vendors are more careful about checking IDs.

- Bubba Smith, former Michigan State and NFL defensive end, was featured in a well-known Miller Lite ad campaign in the late 1970s. Upon visiting his alma mater in 1985, Smith realized he was better known for "Tastes great! Less filling!" than for his efforts on the field and decided to quit the Miller Lite team. "I don't like the effect I was having on a lot of little people, people in school. When kids start to listen to what you say, you want to tell 'em something that's the truth...Doing those commercials, it's like me telling everyone in school, 'Hey, it's cool to have a Lite beer' ... As the years wear on, you got to stop compromising your principles."

- In Austria, laws prohibit all public reference at sporting events to "alcoholic beverages, tobacco, pharmaceutical products, political parties and religious communities," in that order. Ironically, in a country that prides itself on brewing some of the world's finest beers, the concept of a brewery being involved in sports is unthinkable.

- Twenty percent of beer-drinking males between the ages of 18 to 34 account for 70% of all beer consumed in the U.S.

###

Alcoholics who quit drinking, even after at least five years of heavy drinking, can live as long as casual drinkers, or even teetotalers, a new study has found. Research has shown that alcoholics who continue drinking die 10 to 15 years prematurely, and that those who quit drinking extend their life expectancy. The death rate for the actively alcoholic man is greater the younger he is.[11]

###

According to Dr. Alexander Wagenaar, Director, Alcohol and Other Drug Epidemiology Program, University of Minnesota School of Public Health, alcohol was involved in:

- nearly 32% of aviation deaths
- 62% of drownings
- 48% of falls
- 54% of fires
- 40% of industrial injuries[12]

###

About drunk and drugged driving:[13]

- Highway crashes involving drivers (and pedestrians) who are impaired by alcohol and/or other drugs are not "accidents." They are preventable.

- About 20,000 Americans died in these crashes in 1991, more than one-third of them under the age of 25.

- Alcohol-related highway crashes are the leading cause of death for adolescents and young adults in the U.S.

- In spite of the minimum legal drinking age now set at 21 in all States, 30 percent of fatally injured drivers under 21 had blood alcohol concentrations (BAC) of .02% or above.

- Teenagers are at high risk for alcohol-related highway crashes. According to a March 1989 report, nearly half of 10th graders and a third of 8th graders reported riding during the past month with a driver who had used alcohol or other drugs before driving.

- Five States have followed recommendations of most experts to lower the BAC to .08% for drivers 21 and over. This recognizes research showing that any measurable alcohol increases the crash risk for some drivers and that the risk increases substantially by .08% BAC. Most States consider a blood alcohol concentration of .10% as legal intoxication.

- The average amount of alcohol consumed by persons arrested for driving under the influence is very high. On average, their BACs register the pure alcohol bloodstream equivalent of 10 to 12 drinks in a 4-hour period or BACs greater than .15%.

- In addition to saving lives and avoiding injuries and property damage, preventing impaired driving reduces the costs of private insurance and health care, frees law enforcement personnel to counter other threats to the community's well-being, and relieves over-burdened court and prison systems.

- Localities that have adopted Administrative License Revocation (ALR) measures, empowering law enforcement personnel to confiscate licenses of impaired drivers on the spot, report decreased impaired driving, and fewer alcohol-involved fatalities.

###

Impact on the workplace:[14]

- Worker compensation claims are three times higher for employees who have problems with alcohol and other drugs than for employees who do not.

- Employees who have problems with alcohol and other drugs are six times more likely to have accidents off the job than are employees who do not have these problems.

- Productivity for problem alcohol or other drug users is 25% to 33% lower than for employees who don't have problems with alcohol or other drugs.

- Among employees tested for drugs, those who tested positive have absentee rates 2.5 times higher than those who tested negative.

- 18% of employees who seek treatment for alcohol and other drug use report that they have stolen from employees or co-workers.

- In 1980, the U. S. government and private insurers spent $10.5 billion on treatment for alcoholism. In 1988, the total was $38 billion, accounting for 7% of all health expenditures in the U.S. that year.

- Among employees who reported alcohol-related problems in the previous year, 9% of those aged 18 to 25 and 4% of those aged 26 to 34 reported drinking on the job.

###

Archaeologists have found evidence of beer as far back as 3500 BC! Patrick McGovern, an archaeological chemist at the University of Pennsylvania and co-author of a study published in Nature, found calcium oxalate deposits in a jar more than 5,000 years old. Calcium oxalate is a substance that settled out when barley beer was stored or fermented.[15]

###

The total cost to the criminal justice system to process drug-related cases in 1991 was $15.4 billion. On the other hand, the amount spent on treatment was only $5.7 billion.[16]

###

Statistics from the 1991 National Household Survey on Drug Abuse:[17]

- Current use (within last 30 days) of any illicit drug declined by more than half between 1985 and 1991 for those aged 12-17. During that period, there was a continuous decline from 14.9% to 6.8%. 1988 and 1990 estimates were 9.2% and 8.1% respectively.

- Current cocaine use in the total population (0.9%) has stabilized since 1990 (0.8%) compared to 1985 (2.9%). As recently as 1988, the rate was nearly twice as high (1.5%).

- Current use of crack has remained at about the same level, e.g., 479,000 or 0.2% of the population since 1988.

- Populations at Risk. Among populations with the highest rates of current use of crack are Blacks (0.7%), the unemployed (1.8%), and those with less than a high school education (0.6%).

- By age, young adults (18-25 years old) have the highest rates of current uses of illicit drugs at 15.4%, followed by youths (12-17 years old) at 6.8%, and adults (26 or older) at 4.5%.

- Among the 18-34 year old unemployed population, 21.5% have used illicit drugs within the last month; however, among the full-time employed in the same age group the rate was only 9.7%.

- Current use of cocaine among the full-time employed 18-34 years old was 1.8%, while among the unemployed it was 4.9%. Within the same age group, current use of marijuana among the unemployed was 18.5%, while among the employed it was 7.9%.

- Among high school dropouts 20-34 years old, 16.6% had used an illicit drug in the past month compared to 9.9% of high school graduates.

- Current marijuana use among high school dropouts 20-34 years old was 14.1% compared to 7.9% of graduates.

###

About marijuana:[18]

- People are usually introduced to marijuana through their friends or family members. Cigarette and alcohol use usually precede marijuana use.

- Today's marijuana is up to 10 times more potent than the marijuana used in the early 1970s.

- The top reasons why kids say they use the drug are: 1) "to feel good/get high," 2) "to have a good time with my friends," 3) "to see what it's like," 4) "to relax" and 5) "to get away from my problems or reduce boredom."

- Common effects of this drug include increased heart rate, bloodshot eyes, a dry mouth and throat, a hacking cough, and hunger.

- Use of this drug may affect one's short-term memory, and the ability to think and feel; may alter one's sense of time, and may reduce one's ability to do things that require concentration and coordination -- such as driving a car or operating machinery.

- The drug weakens the center of motivation in the brain, and can damage it permanently. This causes users to lose interest in school or work and causes listlessness, difficulty in learning new information, disregard for appearance, and an inability to cope with frustration.

- Marijuana inhaled into the lungs damages the lungs and respiratory system in the same way cigarettes do. This can lead to emphysema. Marijuana smoke contains more carbon monoxide and cancer-causing chemicals than tobacco smoke.

- Many believe that marijuana is not addictive because the withdrawal symptoms from the drug tend to be mild. Withdrawal symptoms seem relatively mild because marijuana is stored in fatty tissues of the body. This means the body has its own supply of the drug for months after the habit is kicked.

- After smoking one joint, 10% to 20% of the drug (the chemical THC) is still present in body cells at 30 days; and traces of THC can be found up to four and a half months after stopping the drug.

- It has been proven that long-term marijuana users develop psychological dependence and tolerance to the drug (needs increasing amounts to get "high").

- Because the drug inhibits nausea, people who have marijuana stored in their bodies can drink heavily without getting sick. This can lead to alcohol abuse, drunk driving, and death from alcohol overdose.

- After a marijuana cigarette, it takes six hours or more before a user is considered able to drive a car, or operate a complex piece of equipment properly -- even though he or she may feel "normal."

###

The ability to "send" documents over ordinary phone lines has made the fax machine "the technology of choice" for relaying illegal and unlawful transactions in a host of related criminal activities, such as gambling, fraudulent wire transfers, money laundering, espionage, drug dealing, and gang, organized and occult crime. A newly announced piece of equipment called the FAX GUARDIAN has arrived for use by law enforcement agencies. This portable system can operate on either AC, 12v DC, or an optional nicad battery pack. The FAX GUARDIAN prints duplicates of all documents that are either being sent or received by the fax machine being monitored. It is connected to the telephone line of the fax machine to be monitored at any point along the circuit to the main switching station. The system is totally undetectable on the line making it ideal for use interagency, fixed stationary or active field operations.[19]

###

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2. Monday Morning Report, Vol 16, No. 21, 9 Nov 92.

3. RADAR Network Alert, OSAP, 15 Jun 92, Vol. 3, Nos. 187-231.

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FIND-A-WORD PUZZLES

DRUG FIND-A-WORD

Circle the clue words found in the grid below.

L	A	D	H	H	T	A	E	D	L
O	D	E	P	T	W	G	I	R	B
S	I	M	Z	S	C	E	N	U	M
S	S	I	E	D	C	F	C	N	U
I	C	T	N	I	O	J	I	K	D
S	H	E	I	A	L	S	D	G	C
Y	A	N	L	S	I	L	E	A	O
L	R	O	P	I	D	Y	N	C	C
A	G	S	I	L	R	A	T	R	A
N	E	D	C	K	U	P	S	A	I
I	D	I	S	J	G	M	N	C	N
R	T	O	I	P	S	M	O	K	E
U	S	R	D	O	V	E	R	S	V
N	A	V	Y	Y	B	T	T	A	R
M	M	O	N	E	Y	H	D	F	H

AIDS
BRIG
DEATH
DISCHARGED
DISCIPLINE
DRUGS
DRUNK
DUMB
COCAINE
CRACK
ICE
INCIDENT
JOINT
LOSS
LSD
MARIJUANA
MAST
METH
MONEY
NAVY
ONE TIME
OVER
PAY
ROIDS
SICK
SMOKE
SNORT
TAR
URINALYSIS

TO FIND OUT MORE ABOUT DRUG ABUSE, ATTEND PREVENT -- CALL YOUR DAPA ON

###

ALCOHOL FIND-A-WORD

Circle the clue words found in the grid below.

M	T	N	E	M	T	A	E	R	T
A	R	E	E	B	C	F	S	I	L
D	E	T	C	I	D	D	A	P	A
D	S	V	O	P	R	S	E	U	M
T	U	X	I	A	T	M	S	S	W
N	B	B	D	R	F	E	I	R	H
E	A	H	I	T	D	L	D	E	I
V	W	P	J	Y	O	L	R	V	S
E	E	B	N	H	L	S	I	O	K
R	R	A	O	M	S	O	N	G	E
P	B	C	Y	I	H	Q	K	N	Y
B	L	A	C	K	O	U	T	A	R
A	P	K	T	V	T	X	Z	H	A

ABUSER
ADDICTED
ALCOHOLISM
BAC
BEER
BLACKOUT
BREW
DAPA
DISEASE
DRINK
DRIVE
HANGOVER
MADD
NO
PAY
PARTY
PREVENT
SHOT
SICK
SMELL
STRIPE
TREATMENT
WHISKEY

TO FIND OUT MORE ABOUT ALCOHOL ABUSE AND ALCOHOLISM, ATTEND PREVENT . . . CALL YOUR DAPA AT

OBESITY FIND-A-WORD

Circle the clue words found in the grid below.

D	P	O	U	N	D	S	A	D	D
O	E	B	T	H	E	P	T	T	L
F	I	S	H	D	T	G	P	E	E
D	S	I	C	K	N	T	I	A	S
W	L	T	H	I	N	G	C	T	I
O	U	Y	B	D	H	U	F	M	C
H	P	Y	R	E	V	O	C	E	R
C	M	Y	B	N	D	E	F	N	E
B	O	D	Y	I	Z	H	S	T	X
K	C	E	G	A	M	I	M	E	E
O	A	R	R	L	O	S	E	I	I
J	O	G	E	L	A	C	S	D	P

ATE
BINGE
BODY
CHOW
CFC
COMPULSIVE
DAPA
DENIAL
DIET
EAT
EXERCISE
FISH
FOOD
GRAZE
IMAGE
JOG
LOSE
OA
OBESITY
OVEREATER
PIE
POUNDS
RECOVERY
SAD
SCALE
SICK
THIN
TREATMENT
WEIGH

TO FIND OUT MORE ABOUT THE NAVY'S TREATMENT FOR CHRONIC OBESITY, CALL YOUR DAPA AT

###

AFTERCARE FIND-A-WORD

Circle the clue words found in the grid below.

N	R	E	B	O	S	C	U	R	E
R	E	F	I	T	D	B	P	O	Y
U	L	I	D	F	N	L	M	U	T
T	Y	L	O	N	E	O	E	G	U
E	G	H	I	H	I	N	E	H	D
R	E	R	A	C	R	E	T	F	A
C	S	E	E	P	F	L	I	K	P
R	K	L	G	C	P	Y	N	M	A
A	N	A	L	A	O	Y	G	E	N
V	I	P	A	A	O	V	S	A	D
I	R	S	D	C	T	S	E	R	A
N	D	E	R	I	T	R	T	R	Y
G	N	I	L	E	S	N	U	O	C

AA
AFTERCARE
CAAC
COUNSELING
CRAVING
CURE
DAPA
DAY
DRINKS
DUTY
FIT
FRIENDS
GLAD
HAPPY
HELP
LIFE
LONELY
MEETINGS
NA
OA
ONE
RECOVERY
RELAPSE
RELY
REST
RETURN
ROUGH
SAD
SOBER
TIRED
TRY

FOR MORE ABOUT AFTERCARE, CALL YOUR DAPA ON

FEATURE ARTICLES

ALCOHOL ABUSERS[1]

Individuals who experience a variety of social and medical problems as a result of high-risk drinking but who are not dependent on alcohol are called alcohol abusers or non-dependent problem drinkers. Alcohol use by these people often leads to problems that arise from impaired judgment, diminished concern about the consequences of behavior, and the physical effects of alcohol consumption. Such adverse events may be the result of a single bout of drinking or they may represent the effects of frequent high-risk alcohol use. These individuals may also be in the early stages of alcoholism.

The Navy defines alcohol abuse as, "the use of alcohol to an extent that it has an adverse effect on the user's health, behavior, family, community, the Navy, or leads to unacceptable behavior as evidenced by one or more alcohol incident(s)." An alcohol incident is conduct or behavior, caused by the ingestion of alcohol, which results in discreditable involvement with civil and/or military authorities. Events requiring medical care or involving a suspicious public or domestic disturbance are evaluated to determine if alcohol was a contributing factor and, if so, are considered alcohol incidents. Examples of alcohol incidents by Navy men and women include driving while intoxicated (DWI), drunk on duty, drunk and disorderly, drunk in public, brawling, and child or spouse abuse while under the influence. It is sometimes hard to draw exact lines between social drinking, problem drinking, and alcohol dependence. Generally speaking, however, social drinking becomes an alcohol problem when drinking repeatedly harms the drinker or those close to him or her.

Navy Programs For Abusers

Navy men or women who are identified as abusing alcohol are screened at one of 80 Counseling and Assistance Centers (CAACs) by a Navy Drug and Alcohol Counselor to determine the severity of the problem and the appropriate level of treatment. If the member is thought to be alcohol dependent, he or she is sent to a Navy physician or clinical psychologist for a diagnosis using the criteria listed in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition--Revised). If found to be an alcohol abuser, the person will enter a Level II (CAAC) program. CAAC programs include attendance at group and individual counseling and education sessions which address behavior changes leading to a healthy lifestyle. If the alcohol incident is thought to be an isolated episode, the person will be placed in a Level I (command) program. Command programs vary widely but usually include attendance at the 36-hour Personal Responsibility and Values Education and Training (PREVENT) formerly called NADSAP--

mandatory for anyone receiving a DWI, attendance at some open Alcoholics Anonymous (AA) meetings, some type of disciplinary action, and chain of command counseling.

For more information on alcohol abuse and alcoholism, contact your Command Drug and Alcohol Program Advisor.

###

1. Alcohol and Drug Abuse Manager/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

ALCOHOLISM[1]

Definitions

There are just about as many definitions of alcoholism as there are brand names of alcoholic beverages. The Navy defines alcoholism as, "a disease characterized by psychological and/or physical/physiological dependence on alcohol." It continues the definition as "clinically defined as a cluster of cognitive, behavioral, and physiologic symptoms that indicate the person has impaired control of alcohol and continues use of the substance despite adverse consequences."

The American Society of Addiction Medicine and the National Council of Alcoholism and Drug Dependence jointly define alcoholism as, "...a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial."

A late 1980's Presidential Commission on Law Enforcement and Administrative Justice sponsored a task force on drunkenness which defined the chronic alcoholic as "any person who chronically and habitually uses alcoholic beverages to the extent that it injures his or her health or interferes with his or her social or economic functioning to the extent that she or he has lost the power of self-control with respect to the use of such beverages."

Perhaps part of the problem in developing a short, concise definition of alcoholism is because there is such a variance among alcoholics themselves. They have different drinking patterns (episodic, binge drinking, daily drinking, etc.), different choices of alcoholic beverages ("hard" liquor, wine, beer, etc.) and different quantities consumed (a "few sips," several six-packs, a fifth a day, a few glasses of wine with dinner, etc.). Focus on the disease should not be on the differences but on the fact of uncontrolled drinking despite the consequences.

Causes

To add even more confusion there are many "theories" of what causes alcoholism. One theory, diminishing in popularity, is that alcoholism is a "moral weakness" -- that the alcoholic could stop drinking if he or she "would just use a little willpower."

Other theories regarding the cause of alcoholism include:

--That anyone who drinks enough over a long period of time can become alcoholic.

--That alcoholism is an environmental product--influenced by one's surroundings. There are areas of the country where drinking is much more acceptable than in other areas; and, therefore, more drinkers can be found there. There are also occupations which appear to attract heavy drinkers. These include popular musicians, house painters, poets, novelists, salesmen, career soldiers and sailors, and coal miners.[2]

--That alcoholism is caused by an individual's "allergy" to alcohol -- that this person metabolizes alcohol differently than others.

--That it is caused by either a deficiency or excess of neurotransmitters in the chemical make up of the brain.

--That the disease is genetically influenced. Research has made it increasingly clear that the genes people inherit can contribute to the development of alcoholism. In the last few years, studies have persuasively demonstrated that approximately one half of all alcoholic persons have inherited a genetic predisposition--or susceptibility--to the disease. Studies of twins and adoptees have shown that children who have a biological parent who is alcoholic are four times more likely to develop alcoholism than the children of non-alcoholics. For sons of alcoholic fathers, the risk is even higher. This is true regardless of the environment in which they are raised.

To find out more about the disease of alcoholism, contact your Command Drug and Alcohol Program Advisor (DAPA).

###

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2. Wallace, John, Alcoholism: New Light on the Disease, Edgehill Publications, 200 Harrison Ave., Newport, RI 02840, 1985.

SOME OF THE WARNING SIGNS AND STAGES OF ALCOHOLISM[1]

The following list is not all inclusive and a "diagnosis" or "label" of alcoholism should not be based upon these warning signs. In the Navy, only physicians and clinical psychologists can make that call.

--Trying to cut down or to quit drinking but failing at it.

--Blackouts (a blackout is not being so drunk that the person can't remember anything, or passing out; a blackout is simply an amnesia for an event that occurred the previous day or evening, as though it had been erased from the memory completely) or lapses of memory, after use.

--Drinking alcohol while alone, or hiding the evidence of use.

--Using alcohol to forget about problems or worries or to relieve stress, fear, shyness or insecurity.

--Doing things while "under the influence" that cause regret afterwards.

--Becoming more moody, jealous or irritable after drinking.

--Being irritated when family or friends discuss drinking.

--Feeling guilty about drinking.

--Not being able to enjoy an event without alcohol.

--Using much more than other people in a social gathering.

--Neglecting responsibilities in order to use alcohol.

--Losing time from duty due to drinking.

--Family, friends or supervisor expressing concern about alcohol use.

--Being willing to do almost anything to get alcohol.

--Financial or legal problems from using alcohol.

Stages of the Disease

As a chronic disease, alcoholism goes through stages like other chronic diseases. Most of us can recognize someone in the later stages--but the early stages can be deceptive. An old Japanese proverb is very descriptive of the stages:

"First the man takes the drink." Early, adaptive stage:

--Can choose when to drink. The body is adapting to alcohol. At this stage the alcoholic shows a high tolerance for alcohol. He or she can drink a lot. The individual may have an alcohol incident in this stage; can stop drinking, for awhile, if pressured to.

"Then the drink takes the drink." Middle stage:

--Is beginning to lose the choice about when to drink. Loses control of drinking when started; can't predict what will happen. He/she begins to become physiologically adapted to alcohol and begins to drink for relief (to ward off withdrawal symptoms). The alcoholic starts to feel better when drinking than when not drinking. At this stage, the alcoholic will deny or downplay the amount he or she drinks.

"Then the drink takes the man."

--Loss of control is total. Must drink. No joy left in drinking; drinks to ward off acute withdrawal symptoms (in fact, drinks to function). Many health complications surface.

At this stage, the individual will still deny that alcohol is the problem--blames other people or circumstances.

For more information on the disease of alcoholism, contact your Command Drug and Alcohol Program Advisor (DAPA).

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

PREVALENCE OF ALCOHOL ABUSE AND ALCOHOLISM[1]

In 1990, as many as 10.5 million Americans showed signs of alcoholism or alcohol dependence, and another 7.2 million showed persistent heavy drinking patterns associated with impaired health and/or social functioning. By 1995, alcohol-dependent adults will number 11.2 million, with the number of persistent heavy drinkers remaining the same.[2]

Data extracted from the National High School Senior Survey shows high school seniors self-reporting:

Survey Year	1975	1985	1990	1991	1992
Seniors who had ever used alcohol	90.4%	92.2%	89.5%	88.0%	87.5%
Seniors who had used alcohol within the last year	84.8%	85.6%	80.6%	77.7%	76.8%
Seniors who had used alcohol within last 30 days	68.2%	65.9%	57.1%	54.0%	51.3%

The National Institute on Drug Abuse's 1991 National Household Survey on Drug Abuse reports the following:

Age Group	Ever Used Alcohol	Used Alcohol Within Past Year	Used Alcohol Within Past Month
12-17	46.4%	40.3%	20.3%
18-25	90.2%	82.8%	63.6%
26-34	92.4%	80.9%	61.7%
35+	87.4%	64.9%	49.5%

For the Navy, the DoD Worldwide Survey of Substance Abuse and Health Behaviors Among Military Personnel shows:

Survey Years	1980	1982	1985	1988	1992
Alcohol Drinking Levels					
Abstainer	10.0%	10.5%	9.6%	15.7%	20.2%
Infrequent/light	11.7%	20.7%	18.8%	18.3%	19.0%
Moderate	20.5%	15.1%	18.7%	20.9%	20.2%
Moderate/heavy	32.2%	26.1%	27.9%	30.5%	26.9%
Heavy	25.6%	27.7%	24.9%	14.6%	13.8%

For survey purposes, the drinking level classification was based on quantity and frequency data during the past 30 days for the respondent's primary beverage. Abstainers drank once a year or less. Those in the infrequent/light category drank 1 to 3 times a month and 1 to 4 drinks per occasion. Those in the moderate category drank (a) at least once a week and 1 drink per occasion, (b) 2 to 3 times a month and 2 to 4 drinks per occasion, or (c) once a month or less and 5 or more drinks per occasion. Those in the moderate/heavy category drank at least once a week and 2 to 4 drinks per occasion or 2 to 3 times per month and 5 or more drinks per occasion. Those in the heavy category drank at least once a week and 5 or more drinks per occasion.

The trend in average daily ounces of ethanol consumed in the past 30 days by Navy men and women is:

Survey Years	1980	1982	1985	1988	1992
	1.64	1.58	1.46	1.02	0.94

The trend in productivity loss due to alcohol ingestion in the past 12 months for Navy men and women is:

Survey Years	1980	1982	1985	1988	1992
	34.7%	41.8%	35.5%	26.4%	20.1%

The following excerpts from the 1992 Survey give a picture of the scale of the problem within the entire Department of Defense:

- Alcohol-related negative effects (any serious consequences, productivity loss, and dependence) have declined significantly since 1980. In 1992, 7.6% of all military personnel experienced at least one alcohol-related serious consequence, 16.4% had some alcohol-related productivity loss, and 5.2% showed signs of alcohol dependence. Between 1988 and 1992 all three measures showed a declining pattern, but only the decrease in productivity loss was statistically significant.

- Alcohol-related serious consequences, productivity loss, and dependence were substantially higher among the E1-E3 pay grades than among other pay grades. For any serious consequences and symptoms of dependence, rates for E1-E3s were almost three times as high as the rates for E4-E6s and for productivity loss, more than 10 percentage points higher.

- The prevalence of heavy drinking decreased significantly from 1980 to 1992 for the Navy and the Air Force. Heavy drinking in the Army was at about the same level in 1992 as at

the start of the Worldwide Survey series in 1980, and heavy drinking among Marine Corps personnel has not shown any significant declines across the survey years.

- Relatively few military personnel (6.2% of all personnel, 6.5% of enlisted personnel and 4.4% of officers) reported drinking on any of the following occasions: within 2 hours of going to work, during lunch break, or during work or work break in the past 30 days. These rates are significantly lower than in 1988 when 10% of all military personnel engaged in one or more of these behaviors.

- Military personnel overall and military men specifically were significantly more likely to drink heavily than were their civilian counterparts (14.5% of all military personnel vs 9.5% of civilians; 16.2% of military men vs 10.5% of civilian men).

- The rate of heavy drinking for men aged 18 to 25 was roughly twice as high for military personnel as for civilians (25.9% vs 13.8%).

- The rate of heavy drinking among women in the military (4.3%) was not significantly different from the standardized rate among civilian women (3.5%).

Contact your Command Drug and Alcohol Program Advisor (DAPA) for more information on the Navy's alcohol and other drug abuse program.

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

2. National Council on Alcoholism and Drug Dependence, Alcoholism and Alcohol-related Problems, Rev 11/90.

ALCOHOL ABUSE VS ALCOHOLISM

It is important to understand the differences between alcohol abuse and alcoholism because the "treatment" of each varies widely.

People who abuse alcohol do so, generally, out of boredom, because of peer pressure, or as a means of coping. These three reasons are preventable; through enough alternatives to drinking out of boredom; through a command climate that insists that to not drink is ok and that drunkenness has severe consequences; and through programs such as Personal Responsibility and Values Education and Training (PREVENT--formerly known as NADSAP) which teach healthier coping skills. When alcohol abuse becomes evident through an alcohol-related incident, Level I (command) and II (Counseling and Assistance Centers (CAACs)) should be used to address the problem.

Level I programs should include education about the consequences of abuse; leaders setting a positive role model and availability of problem-solving avenues (e.g., Family Service Centers, Chaplains, Navy Relief, courses in stress reduction, financial planning, decision making and healthy relationships, etc.). Disciplinary consequences of alcohol abuse should be meted out fairly and swiftly.

Level II, CAAC, programs include competent, trained staff members who provide outpatient individual and group treatment and education with continuing individualized treatment through aftercare.

Individuals with the disease of alcoholism, treated at a Level III facility (Navy Alcohol Rehabilitation Centers/Departments), will benefit from all of the above but will not be able to "cure" the disease through these avenues. Level III treatment includes: complete abstinence from alcohol (both while in treatment and as a life-long goal); physical assessment and medical management of health problems; competent, trained staff including physicians, counselors, chaplains, physical fitness coordinators; military leadership and discipline; individual and group treatment; education programs; an introduction into a life-long recovery program; and individualized aftercare planning. Briefly, the difference between abuse and disease:

--The abuse is voluntary--the abuser can be taught/made to not abuse.

--Alcoholism is not voluntary--alcoholics cannot choose to not have the disease.

--Abusers may respond to discipline, education and counseling.

--Alcoholics may respond to life-long treatment of the disease.

To find out more about alcohol abuse and alcoholism, contact your Command Drug and Alcohol Program Advisor (DAPA).

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

ALCOHOL AND WOMEN[1]

It has been a long-standing myth that the reason women could not "hold their liquor" was because they were smaller than men or that their bodies carried proportionally more fat and less water in their bodies than men (alcohol being diluted more gradually and getting into their tissues more rapidly). Researchers have found that women have far smaller quantities of the protective enzyme, alcohol dehydrogenase, that breaks down alcohol in the stomach. The enzyme is crucial to curbing intoxication. Having less of this enzyme results in women absorbing about 30 percent more alcohol into their bloodstreams than men do. Taking into account the weight difference between the average man and woman, two ounces of liquor has about the same effect on a woman as four ounces would on a man.

The research has also shown that alcoholic men have about half as much alcohol dehydrogenase as their counterparts, and alcoholic women show almost no enzyme activity at all. The result may be that alcohol may injure the stomach wall, where the enzyme is manufactured. Alcoholic women appear to lose all gastric protection; it has been said that for them to drink alcohol is the same as shooting it up directly into their veins.

Contact your Command Drug and Alcohol Program Advisor (DAPA) for more information on the Navy's alcohol and other drugs program.

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

ALCOHOL AND AIDS[1]

Alcohol and other drug abusers are considered "high risk" for HIV infection. Alcohol attacks the part of the brain that controls inhibitions and often causes people to do things they wouldn't ordinarily do and may regret later. Alcohol can impair a person's ability to think clearly and behave responsibly, including using protection when engaged in sexual activity, to reduce the risk of HIV infection.

In addition, alcohol can impair normal immune responses that protect the body from disease. Chronic alcohol consumption has been shown to reduce the number of infection-fighting white blood cells in laboratory animals and in humans.[2]

For more information on the Navy's alcohol and other drugs program, call your Command Drug and Alcohol Program Advisor (DAPA).

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

2. National Institute on Alcohol Abuse and Alcoholism, Alcohol Alert, No. 15, PH311, Jan 1992.

FAMILIES AND ALCOHOLISM[1]

Alcoholism (as with all addictions) is a family disease that has a devastating impact on each individual family member and on the family system as a whole.

In any family, the life of each member is joined with and affected by all the others, and may be seriously disturbed by the illness of another family member. This is not just the case with alcoholism--it happens with any major illness. If a parent or child is dying of cancer, for example, it is easy to see how an entire family is affected by and has to deal with the disease.

Because of the stigma attached to alcoholism, families often find themselves living in a virtual state of isolation. Family members may feel ashamed or embarrassed by the alcoholic person's behavior, guilty about not doing enough to help or even believing they caused the drinking, and often responsible for trying to get the alcoholic member to stop drinking. Sometimes family members will make excuses for the drinking or deny that it is harmful. Frequently, families deny that there is any problem at all.

Depending on the nature and duration of active alcoholism, family members will be affected differently and, like the alcoholic member, may need different types of treatment. Help is available for alcoholic families through support groups such as Al-Anon and Alateen. These 12-step support groups meet to share experiences, strength and hope with each other, discuss their difficulties and learn effective ways to cope with their problems. Local telephone directories usually carry a phone number for an Al-Anon/Alateen contact who can provide information on where and when meetings will be held. If no local listing is provided, individuals can contact the Al-Anon Family Group Headquarters, P.O. Box 862, New York, NY 10018-0862, 212-302-7240 (1-800-344-2666 between 0800 and 1800 EST on weekdays).

Responses to questionnaires sent to adult children of alcoholics have revealed that 37 percent described themselves as alcoholic, they more often married alcoholics, and they more frequently had alcoholic relatives. Family disruption (e.g., divorce, death), verbal arguments, physical violence or abuse, and feelings of responsibility for parent conflict were reported more often in the childhoods of adult children of alcoholics than in a control group. Other research has shown that adult children of alcoholics have poor communication skills, difficulty expressing feelings, role and identity confusion, and overresponsibility.

Recovery support groups for adult children of alcoholics have been formed. For more information, write or call Adult Children of Alcoholics, World Service Organization, P.O. Box 3216, Torrance, CA 90510 (telephone 310-534-1815).

The Navy encourages, to the extent feasible, family participation in the treatment process. At Counseling and Assistance Centers (Level II) and Navy Alcohol Rehabilitation Centers/ Departments (Level III), family involvement increases the potential for successful outcome. Family members are afforded the opportunity for education, counseling and rehabilitation on a space/time available basis. Additional resources are available through Family Service Centers, naval hospitals, and CHAMPUS providers.

For more information on the Navy's alcohol and other drug abuse programs, contact your Command Drug and Alcohol Program Advisor (DAPA).

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

BLOOD ALCOHOL CONCENTRATION (BAC)[1]

A "typical" drink, such as a can of beer, a glass of wine, or a shot of liquor, contains just over one half ounce of pure alcohol. However, many drinks contain more alcohol than the "typical" drink, such as:

-Martini, Manhattan, Black Russian = 2 typical drinks
-Margarita, Daiquiri, Ale, Wine Cooler = 1.5 typical drinks
-Beer, Wine, Sherry, Highball, Liqueur = 1 typical drink

Blood alcohol concentration, or BAC, is a measure of the amount of alcohol in the blood. Blood alcohol is measured directly through testing blood, or indirectly through tests that use breath, urine, or saliva.

Most states consider a person too intoxicated to drive when his or her BAC reaches .10%. Some states have lowered the BAC limit to .08%. At a BAC of .10%, there is roughly one drop of alcohol in the blood stream to every 1,000 drops of blood.

Many factors affect an individual's absorption of alcohol. These include weight, sex (women have smaller quantities of the enzyme which breaks down alcohol in the stomach), amount of food in the digestive tract, and time spent drinking (and the corresponding rate of elimination).

The greatest number of fatal motor vehicle accidents for 16-24 year olds occurred at a much lower level of BAC than for those in older age groups. Since 1983, every state has enacted laws raising the minimum age for the purchase or sale of alcoholic beverages to 21. Some states are in the process of enacting legislation which would make .02% BAC the level of driving while under the influence for anyone under the age of 21.

For most people, the obvious effects of alcohol consumption, such as inappropriate behavior or gross motor impairment, are needed to determine that an individual is too drunk to drive. People assume that drivers must appear drunk before they are too intoxicated to drive.

The legal offense, however, is driving while impaired by alcohol. Physiological changes, which may not be evident, can lower one's driving ability and are the basis for driving under the influence (DUI) laws. A person can be sufficiently impaired to be a danger behind the wheel without looking drunk.

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[1] Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

Alcoholics or alcohol abusers with a high tolerance can walk, talk and appear to perform quite well at very high BAC levels. Chronic alcoholics in the later stage of their disease generally are functional at the BAC range of .15% to .25%.

For more information, contact your Command (DAPA).

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COCAINE[1]

Throughout history, cocaine has been a drug of both initial promise and ultimate disappointment. Over the years many so-called medical experts have declared cocaine to be a "wonder drug" that was "nonaddicting," only to have the real facts about cocaine destroy these dangerous myths. Cocaine may actually be the most addicting substance known to man.[2]

Some enterprising street chemists found a way to convert cocaine into a smokable drug. Smoking gets the cocaine into the lungs, permitting greater absorption and the most rapid delivery of the drug to the brain. By going through the lungs, cocaine reaches the brain within only 5 to 8 seconds compared to the 15 to 30 seconds when injected.

"Freebasing" allowed users to smoke the drug and ingest much higher doses than ever before. However, freebasing was a time-consuming and dangerous procedure. Some users combined cocaine and heroin in a drug cocktail known as a "speedball." Crack is simply freebase prepared by a different method. The popularity of crack compared with freebase is largely a product of marketing techniques that make small amounts of high-quality cocaine available at low prices and without having to undertake a dangerous chemical process to convert cocaine to a smokable form.

The words "crack cocaine" appeared on U.S. streets and in the media in 1985--by 1986 there seemed to be a crack epidemic that crossed all social and economic barriers.[3]

The "crack" form of cocaine gets its name from the sound it makes in the glass pipe during heating, the vaporization and subsequent inhalation. Crack is freebase produced by mixing cocaine hydrochloride with water and baking soda or sodium bicarbonate and boiling it until a chip or chunk remains. Crack is usually sold in small crack vials, glassine baggies, film canisters, etc. Sizes of the "rocks" are imprecise, but generally range from 1/10 to 1/2 gram. These rocks can sell for as low as $3 to as high as $75, but prices generally range from $10 to $50. The national range for ounce quantities of crack is between $650 to $2,500; a gram ranges in cost between $30 to $130.[4]

Crack differs from the powdered form of cocaine in several ways. Because it is smoked, the user feels a "high" in less than 10 seconds. Sniffing cocaine produces a high after a one to two minute delay. The feeling of euphoria from crack wears off after five to fifteen minutes; the effects of snorted cocaine may last slightly longer. Another difference is that the crack-induced euphoria is far more powerful than that created by powder. The

smoked drug is absorbed rapidly from the lungs to the heart and then to the brain. After the high is over, the crack user feels anxious, depressed, and paranoid. Such a rapid shift from positive to negative effects makes users crave another "hit" of the drug to get back to the euphoria they felt just moments before.

While crack is not pure (that's one of the myths that surround crack), the process of creating crack from cocaine intensifies the resultant chunk, making it more powerful than cocaine powder.[5]

Data from the 1990 National Household Survey on Drug Abuse showed that the number of current cocaine users--people who had used the drug within the past 30 days--had decreased from 5.8 million in 1985 to 1.6 million in 1990. The number of people who had used cocaine within the year fell from 12 million to 8 million between 1985 and 1988. Cocaine-related emergency room visits declined 26% between 1988 and 1990. Unfortunately, the number of people using cocaine every day or every week rose during the same period. In addition, among the nearly 3 million current users are a half million people who use crack. A 1988 survey by the Drug Abuse Warning Network found that 1 of 4 cocaine-related emergency room visits was related to crack smoking, compared with 1 of 20 in the previous survey.

The cocaine-use trend for Navy personnel self reporting in the DOD Worldwide Survey of Substance Abuse and Health Behaviors Among Military Personnel series is as follows:

Survey year	1982	1985	1988	1992
Used within past 30 days	3.3%	3.3%	.9%	1.1%
Used within past 12 months	9.7%	6.0%	4.2%	2.5%

Contact your Command Drug and Alcohol Program Advisor (DAPA) for more information on the Navy's alcohol and other drug abuse program.

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

2. Gold, Mark S., The Facts About Drugs and Alcohol (Third Revised Edition), 1988.

3. Inada, Darryl; Cohne, William, Uppers, Downers, All Arounders, Cinemed Inc., P.O. Box 96, Ashland, OR 97520, 1990.

HEROIN[1]

Heroin (now claiming street names like "junk" or "horse") was synthesized from morphine in 1874 and was used as a pain remedy until its addiction potential became understood.

For a long time the major producer and exporter of illicit heroin was the Southeast Asian area known as the Golden Triangle. The Drug Enforcement Administration's (DEA) national price range in the second quarter of 1992 for a kilogram of heroin from Southeast Asia was $140,000 to $240,000. Since 1940, Mexico has become the largest supplier of heroin to the U.S. In the early 1980's Mexico became the source of "tar," "black tar," or "tootsie roll"--so called because of the impurities left from the manufacturing process or the presence of additives. Black tar has been reported to be between 60-85% pure. It may be sticky like roofing tar or hard like coal. The DEA's national price range in the second quarter of 1992 for black tar was $120 to $500 per gram.

In addition to "black tar," yet another kind and source of heroin is being introduced into the U.S. From Southwest Asia (Afghanistan, Iran, Pakistan, Turkey and Lebanon) comes "Persian Brown" or "Perze," reported to be 90% pure. The DEA's national price range in the second quarter of 1992 for a kilogram of heroin from Southwest Asia was $80,000 to $200,000.

Pure heroin, rarely sold on the streets, is a white powder with a bitter taste. A "bag"--slang for a single dosage unit of heroin--may weigh about 100 mg, usually containing about five percent heroin.[2] To increase the bulk of the material sold to the user, diluents are mixed with the heroin in ratios ranging from 9 to 1 to as much as 99 to 1. Sugars, starches, powdered milk, and quinine are among the substances added.

With the new awareness of the possibility of contracting HIV/AIDS from shared needles, heroin users are devising a smokable hit; it can be smoked in a water pipe, mixed with tobacco or a joint, or heated on foil and the smoke inhaled through a straw ("Chasing The Dragon's Tail").

Trends of percentages of Navy personnel who self report using heroin in the DOD Worldwide Survey of Substance Abuse and Health Behaviors Among Military Personnel series are as follows:

Survey Year	1982	1985*	1988*	1992*
Used within past 12 months	.9%	.3%	.4%	.1%

*Category became "heroin/other opiates"

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

2. Drug Enforcement Administration, Drugs of Abuse, 1989.

INHALANTS[1]

There are three main types of inhalants--organic solvents (hydrocarbons), volatile nitrites (amyl, butyl, isobutyl), and nitrous oxide. The substances are inhaled from bottles, soaked rags, bags, balloons, gas tanks--to name just a few.

The practice of "sniffing," "snorting," "huffing," "bagging," or inhaling to get high describes various forms of inhalation. If the substance is glue or some other dissolved solid, the user empties the can's contents into a plastic bag and then holds the bag to the nose and inhales ("bagging"). Another method is to soak a rag with the mixture and then stick the rag in the mouth and inhale the fumes ("huffing"). A simple but more toxic approach is to spray the substance directly into the oral cavity. This allows abusers to be identified by various telltale clues, such as organic odors on the breath or clothes, stains on the clothes or around the mouth, empty spray paint or solvent containers, and other unusual paraphernalia.

The term glue sniffing is still widely used to describe a variety of substances which now include "Texas shoeshine," glue, gasoline, thinners, solvents, aerosols (paint, cooking lubricant spray, deodorant, hair spray, etc.), correction fluids, cleaning fluids, refrigerant gases (e.g., fluorocarbons), anesthetics, "whippets" (whipped cream propellants), organic nitrites, and even cooking or lighter gas.

Inhalation of amyl nitrite "poppers" to alter consciousness and enhance sexual pleasure has emerged in recent years. This use has been particularly prominent in the urban male homosexual society. These nitrites (butyl, isobutyl) are marketed under a variety of names -- Locker Room, Rush, Bolt, Quick Silver, Zoom, etc.

Nitrous oxide, "laughing gas," is one of the earliest documented abused inhalants. Nitrous oxide is available in large gas tanks for dental offices and bakeries, whipping cream aerosol cans and small metal cylinders.

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[1] Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

The DoD Worldwide Survey of Substance Abuse and Health Behaviors Among Military Personnel showed self-reported inhalant use by Navy members:

% used past 12 months		% used past 30 days	
1988	1992	1988	1992
1.2	.9	.9	.7

For more information on the Navy's alcohol and other drug abuse programs, call your Command Drug and Alcohol Program Advisor (DAPA).

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ICE[1]

"Ice" is recrystallized methamphetamine--purer and more powerful than regular methamphetamine or "speed." Also known as "Quartz," "glass," and "Hawaiian salt," ice gets its street names from its crystal-clear appearance.[2]

Ice users are seeking a euphoric feeling, mental alertness, a physical activeness, and a sense of control known as "amping." Unlike stimulants which are injected or taken orally, ice can be smoked, so users don't risk infection with an IV needle.

The Drug Enforcement Administration lists the national price range for an ounce of methamphetamine (in the first half of 1992) between $400 - $2,500; for a gram, $30 - $200. The Honolulu Police Department reports that a 10th of a gram will last an addict two days.

Far Eastern drug cartels operating in Hawaii began to import ice in the early 1980's. Honolulu remains the city most affected by the drug; arrests for selling ice doubled from 1988 to 1989. According to a survey by the Institute for Social Research of the University of Michigan, 1.2 percent of the nation's high school seniors said they used ice in 1989; that figure jumped to 3 percent, the highest percentage, for seniors in the West. The number of methampnetamine users seeking medical care jumped 70 percent from 1986 to 1988, according to the Drug Abuse Warning Network of the National Institute on Drug Abuse which compiles emergency-room mentions from more than 700 hospitals.

The Department of Defense Worldwide Surveys of Substance Abuse and Health Behaviors Among Military Personnel show Navy members self-reporting the use of amphetamines/stimulants at:

Survey year	1985	1988	1992
Used within past 30 days	3.2%	1.0%	.2%
Used within past 12 months	5.0%	2.5%	.9%

For more information about the Navy's alcohol and other drug abuse program, contact your Command Drug and Alcohol Program Advisor (DAPA).

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

2. National Council on Alcoholism and Drug Dependence, Inc., 10 Answers To Your Questions About "Ice", 1990.

LSD[1]

LSD is one of the major drugs comprising the hallucinogen class. LSD was discovered in 1938 by Dr. Albert Hofmann, and is one of the most potent mood-changing chemicals. It is manufactured from lysergic acid which is found in ergot, a fungus that grows on rye and other grains. LSD is classified under Schedule I of the Controlled Substances Act, which includes drugs with no medical use and/or high potential for abuse.

LSD, commonly referred to as "acid," is sold on the street in tablets, capsules, or occasionally in liquid form. It is odorless, colorless, and tasteless and is usually taken by mouth.

Often it is added to absorbent paper, such as blotter paper, and divided into small decorated squares, with each square representing one dose. Doses of LSD are measured in micrograms--millionths of a gram. A level teaspoon of table salt weighs abut 4.8 grams or 4,800 milligrams or 4,800,000 micrograms and is equal to 192,000 doses of LSD at about 25 micrograms a dose, enough to produce an hallucinogenic effect.

The Drug Enforcement Administration (DEA) reports that the strength of LSD samples obtained currently from illicit sources ranges from 20 to 80 micrograms of LSD per dose. This is considerably less than the levels reported during the 1960s and early 1970s when the dosage ranged from 100 to 200 micrograms, or higher, per unit.[2]

The effects of LSD are unpredictable. They depend on the amount taken, the user's personality, mood and expectations, and the surroundings in which the drug is used. Usually, the user feels the first effects of the drug 30-90 minutes after taking it. Most of the LSD is expelled from the body in about three days. The physical effects include dilated pupils, higher body temperature, increased heart rate and blood pressure, sweating, loss of appetite, sleeplessness, dry mouth and tremors.

Sensations and feelings change much more dramatically than the physical signs. The user may feel several different emotions at once or swing rapidly from one emotion to another. If taken in a large enough dose, the drug produces delusions and visual hallucinations. The user's sense of time and self change. Sensations may seem to "crossover," giving the user the feeling of hearing colors and seeing sounds. These changes can be frightening and can cause panic.

Although death from an overdose of LSD is virtually impossible, death from LSD abuse has occurred, usually as a result of self-destructive and aggressive behavior often triggered by the hallucinations, delusions, and paranoia suffered by the abusers.

Many users of LSD voluntarily decrease or stop its use over time. LSD is not considered to be an addicting drug since it does not produce compulsive drug seeking behavior like cocaine, amphetamines, heroin, alcohol or nicotine. However, in common with many of the addicting drugs, LSD produces tolerance, so that some users who take the drug repeatedly, progressively take higher and higher doses in order to achieve the state of intoxication that they had previously achieved.

The 1992 Worldwide Survey of Substance Abuse and Health Behaviors Among Military Personnel, contracted by the Department of Defense, showed a large increase in E1 to E5 Navy members reporting they had used LSD and other hallucinogens (from .9 percent in 1988 to 6.1 percent in 1992). In 1989, Navy Drug Screening Labs began testing 100 percent of all urine samples for LSD. Any Navy member who has a positive urinalysis result must be mandatorily processed for separation from the service.

If you would like more information about the Navy's alcohol and other drug abuse programs, contact your Command Drug and Alcohol Program Advisor (DAPA).

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

2. National Institute on Drug Abuse, LSD (Lysergic Acid Diethylamide), June 1992.

MARIJUANA[1]

Marijuana comes from the hemp plant, cannabis sativa, which grows in many parts of the world. Drug preparations from the hemp plant vary widely in quality and potency, depending on the type, climate, soil, cultivation, and method of preparation.

Preparations of the drug come in three grades: the cheapest and least potent, called bhang, is derived from the cut tops of uncultivated plants and has a low resin content. Much of the marijuana smoked in the United States, particularly back in the sixties and seventies, is of this grade. Ganja is gotten from the flowering tops and leaves of carefully selected cultivated plants, and it has a higher quality and quantity of resin. The third and highest grade of the drug (called charas in India) is largely made from the resin itself, obtained from the tops of mature plants; only this version of the drug is properly called hashish. Hashish can be smoked, eaten, or drunk. Recently, more potent and more expensive marijuana from Thailand, Hawaii and California has become available in this country.[2]

Marijuana contains hundreds of chemicals which affect the mind and body. Among the chemicals causing the "high," THC (delta-9-tetrahydrocannabinol) is the main ingredient. The amount of THC and other chemicals varies greatly in different marijuana plants and from street dose to street dose.

THC is absorbed through the lungs into the blood stream almost immediately after smoking, where it clings to the fatty linings of the cells. It is then released back into the blood stream over a period of time, usually a week or so. Some drugs that are soluble in water, such as alcohol and cocaine, are rapidly expelled from the body. But THC residue remains attached to fat cells, and unless no more marijuana is ingested before the system is cleared, there is a cumulative effect. In order to eliminate totally the residue of drug from one's body, he or she must not use the drug more than once a week. However, if someone is a regular smoker (two joints per week for six months) the fatty areas of the body can be completely saturated with the drug. Traces of THC can be found in the body after several months have passed.[3]

It is impossible to predict how anyone is going to react to marijuana because reactions vary according to the individual's tolerance and the amount of THC and other chemicals delivered to the brain. Generally, the most common response is a calm, mildly euphoric state in which time slows and sensitivity to sights, sounds, and touch is enhanced.

It is dangerous to operate complex machinery, including automobiles, under the influence of marijuana, because it slows reaction time and impairs attention and coordination. Marijuana may influence ability to think or drive for several hours after the "high" feeling has passed even though the individual is not aware of it.

The 1992 DOD Worldwide Survey of Substance Abuse and Health Behaviors Among Military Personnel, shows a continuing decline in the number of Navy members who use marijuana:

Survey Years	1980	1982	1985	1988	1992
Using Marijuana	32%	13.4%	7.0%	3.5%	1.8%

Call your Command Drug and Alcohol Program Advisor (DAPA) for more information about the Navy's alcohol and other drug abuse programs.

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

2. Drug Enforcement Administration, Drugs of Abuse, 1989.

3. Drug Enforcement Administration, Domestic Cannabis Eradication/Suppression Program, December 1991.

PCP[1]

PCP is the drug of many names and reactions--called everything from Angel Dust, Angel Hair, Zombie Dust, Peace Pill, Hog, Elephant Tranquilizer, Crystal, Busy Bee, Superweed, Goon, Mist, Rocket or Jet Fuel, Embalming Fluid, Peep, Killerweed (or KW), Shermans, ozones, Tac, Tic, earth, green, and sheets--the same "hit" can act first as a stimulant then as a depressant and the effects from the same amount can be entirely different each time its used!

PCP was developed in the 1950's for use as a general anesthetic. Because of its side effects of confusion and delirium, it was removed from the market in 1965 and officially limited to veterinary applications.

Most PCP is made in illegal home "labs" by dealers looking for fast profits. A single batch of PCP can be made for around $500 and sold for $300,000 on the street. The DEA reports the national price range in the 2nd quarter of 1992 was $800-$1,900 for a powdered ounce.

In its pure form, PCP is a white crystalline powder that readily dissolves in water. Because of contaminants used in its manufacture, PCP ranges in color from tan to brown and the consistency from a powder to a gummy mass. Although sold in tablets and capsules as well as in powder and liquid form, it is commonly applied to a leafy material, such as parsley, mint, oregano, or marijuana, and smoked.

PCP can produce severe hallucinogenic reactions like LSD but those reactions are often accompanied by violent thoughts or behaviors. Most people who use PCP report a combination of anesthetic, hallucinogenic, stimulant, and euphoric effects at low doses.[2] One of the greatest dangers of PCP use is the unpredictable emotional and psychological reaction it triggers and the behavior that may result. Vehicle crashes, drowning, etc., can result from memory loss, distorted sight perception, poor judgment or loss of coordination. Also, the painkilling effects may lead to unnoticed injury, exposure to extreme heat or cold, etc.

The trend of Navy personnel who self reported using PCP in the DOD Worldwide Surveys of Substance Abuse and Health Behaviors Among Military Personnel are as follows:

Survey Year	1982	1985	1988	1992
Used Within Past 12 Months	1.5%	1.1%	.1%	.4%

Contact your Command Drug and Alcohol Program Advisor (DAPA) for more information on Navy alcohol and other drug abuse programs.

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

2. Gold, Mark S., The Facts About Drugs and Alcohol (Third Revised Edition), 1988.

URINALYSIS[1]

The drug problem in the Navy is real. While the Navy has made progress in the fight against drug abuse, the war hasn't been won.

In 1980, the Department of Defense (DoD) conducted a Survey in which 33% of Navy members admitted using drugs in the past 30 days. Obviously, there was a problem and the Navy got serious about deterring drug abuse.

In 1981, the Navy's expanded forensic urinalysis program was established as the most cost effective and scientifically supportable means of detecting drug abuse. Its visibility and the knowledge of its widespread use (commands test approximately 10 to 20% of personnel each month) have been a great deterrent.

Today the Navy tests for nine drugs--cocaine, cannabis, amphetamines, barbiturates, morphine, codeine, heroin, PCP and LSD. The five Navy Drug Screening Laboratories (NDSLs), located at Norfolk, VA; Jacksonville, FL; Great Lakes, IL; San Diego and Oakland, CA, can test over 2 million samples annually.

The laboratories are monitored through quality control samples provided by the Armed Forces Institute of Pathology and by inspections conducted quarterly by Chief Bureau of Medicine and Surgery and annually by DoD and CNO. Time after time the Navy laboratories have proven to be accurate and reliable.

The radioimmunoassay (RIA) test and the gas chromatography/mass spectrometry (GC/MS) test are two separate tests employing different technologies. The RIA screening test detects a class of drugs. The GC/MS test detects a specific metabolite of a drug. The NDSLs conduct an initial RIA test on all specimens. Negative specimens are discarded. Positive specimens undergo an additional RIA screening test and a GC/MS confirmation test. All three tests must be positive above the established DoD cutoff level before a specimen is reported as positive to a command.

The weakest link in the urinalysis testing program has traditionally been collection. Errors in collection procedures and handling are the main reasons for a Navy urinalysis courts-martial case being lost. Urinalysis convictions can be improved by following the procedures specified in OPNAVINST 5350.4 series and subsequent Drug Abuse Program Advisory Messages more closely and by treating the entire urinalysis program with the priority it deserves.

By 1992, a DoD Survey similar to the one conducted in 1980, showed a major decline in self-reported drug abuse--only 4%.

The results of the Surveys have been validated by the declining percentage of positive findings among samples tested, for example:

	FY-85	FY-87	FY-89	FY-91	FY-92
Samples Tested	1.82M	2.37M	2.06M	1.75M	1.81M
Percent Positive	2.98%	2.37%	1.45%	.64%	.78%

If you want more information on the Navy's alcohol and other drug abuse programs, contact your Command Drug and Alcohol Program Advisor (DAPA).

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1. Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide, Pers-6341, 1993.

TEST YOUR KNOWLEDGE

TEST YOUR KNOWLEDGE

Most people enjoy taking short self-tests (as long as a grade or pass/fail doesn't depend on it) and they are an excellent awareness and education tool.

The following "Test Your Knowledge" questions and multiple choice answers may be run singly or in bunches in a POD or newspaper. If run in bunches, no more than ten at a time should be run because people tend to lose interest if it takes too long. Answers should be printed upside down (at the end of the test) or on a different page. Care should be given to the selection of questions because some contain the same information (e.g., questions 3 and 85 and questions 25 and 26).

Some of the answers may seem to jump right out at you if you are the DAPA; however, remember you have a much greater knowledge of the subject than most of your shipmates. Some of the answer choices may seem absolutely ludicrous (e.g., question 23, choice (d)). Sometimes this enhances the learning by the test-taker. Also, some of the answer choices appear so test-takers can explore or define their own attitudes toward substances and substance users.

You may wish to run a "tag" after each test -- such as "For more information, {see the Command DAPA in room } {attend GNT on } {attend PREVENT} {attend ADAMS}, etc.

The questions and answers were developed using the Alcohol and Drug Abuse Managers/Supervisors (ADAMS) Resource Guide published by the Bureau of Naval Personnel (Pers-6341), in August, 1993.

TEST YOUR KNOWLEDGE

1. Alcohol is
   (a) a stimulant.
   (b) nutritious because it is made from grains.
   (c) a drug.
   (d) not found in beer.

ANS: c

2. In the Navy, after one drug incident, an individual is
   (a) given a second chance if E4 or below.
   (b) mandatorily processed for separation.
   (c) sent directly to Level III treatment.
   (d) automatically given a dishonorable discharge if E6 or above.

ANS: b

3. LSD use is
   (a) on the rise in the Navy.
   (b) a very expensive drug.
   (c) of little concern.
   (d) only for "old hippies."

ANS: a

4. Prescription misuse is
   (a) validated by the Medical Officer.
   (b) not found in the Navy.
   (c) not tested for in the Navy Drug Screening Labs.
   (d) drug abuse.

ANS: d

5. In the Navy, a diagnosis of alcohol dependency
   (a) can be made by a CAAC counselor.
   (b) means mandatory processing for separation.
   (c) made only by a doctor or clinical psychologist.
   (d) can mean treatment at Level I, II or III.

ANS: c

6. You can't be an alcoholic if you are:
   (a) young.
   (b) female.
   (c) abstinent.
   (d) an officer.

ANS: c

7. Features of an addiction include:
   (a) compulsive use/activity.
   (b) loss of control.
   (c) continued use despite adverse consequences.
   (d) all of the above.

ANS: d

8. In the Navy, individuals must complete a one-year monitored aftercare period if they:
   (a) failed Level III treatment but are retained.
   (b) attended Level II or III treatment.
   (c) attended Level I, II or III treatment.
   (d) choose to be treated at the VA.

ANS: b

9. An individual's Aftercare Plan must include:
   (a) daily AA meetings.
   (b) daily contact with the DAPA.
   (c) elements which can be accomplished within the operational constraints of the command.
   (d) weekly CAAC counseling.

ANS: c

10. A member in an aftercare status
   (a) cannot be transferred for one year.
   (b) will automatically be discharged after one year.
   (c) may not drink under any circumstances.
   (d) none of the above.

ANS: d

11. A Drug and Alcohol Program Advisor (DAPA)
   (a) must be an E7 or higher.
   (b) must be a recovering alcoholic.
   (c) must attend training within 90 days of appointment.
   (d) must not drink at command functions.

ANS: c

12. Alcohol is found in
   (a) beer, "hard liquor" and wine.
   (b) root beer, near beer and light beer.
   (c) only "hard liquor" and wine.
   (d) all beverages sold at the Package Store.

ANS: a

13. The body eliminates alcohol at the rate of
    (a) 1 drink every 2 hours.
    (b) 1 standard drink every hour.
    (c) 2 drinks per hour for men weighing 150 pounds or more.
    (d) 3 wine coolers per hour.

ANS: b

14. You can sober someone up by
    (a) cold showers.
    (b) forcing them to drink lots of hot coffee.
    (c) switching them from "hard liquor" to beer.
    (d) waiting.

ANS: d

15. Only alcoholics
    (a) profit from attending AA meetings.
    (b) are treated at Level III.
    (c) have alcohol-related incidents.
    (d) none of the above.

ANS: d

16. Pregnant women
    (a) should not drink alcoholic beverages.
    (b) may drink one glass of red wine per day.
    (c) should stick to beer.
    (d) should drink moderately.

ANS: a

17. Underage drinking
    (a) is allowed at most enlisted clubs.
    (b) is illegal in all 50 States.
    (c) is acceptable at command functions.
    (d) is not considered an incident.

ANS: b

18. Drinking
    (a) has no medical value.
    (b) in the Navy is illegal.
    (c) in limited quantities has been credited with lowering the risk of heart attacks for some people.
    (d) by an alcoholic is OK after the one year aftercare period has passed.

ANS: c

19. In the Navy, alcohol abuse
    (a) has no impact on work performance.
    (b) does not happen because of so many nuclear power skill jobs.
    (c) is tolerated only once.
    (d) may be identified through spouse abuse.

ANS: d

20. Examples of alcohol abuse include
    (a) drunk driving.
    (b) public intoxication.
    (c) drunk and disorderly.
    (d) all of the above.

ANS: d

21. Level I command programs
    (a) may include prevention, education and discipline.
    (b) are reserved for members who have an incident.
    (c) only include attendance at PREVENT.
    (d) do no good.

ANS: a

22. The Navy believes alcoholism is
    (a) a behavior to be changed by discipline.
    (b) a disease.
    (c) a lack of willpower.
    (d) not treatable.

ANS: b

23. Any Navy member who gets a DWI
    (a) is automatically processed for separation.
    (b) must be admitted to Level II treatment.
    (c) must be screened at a CAAC.
    (d) may plead temporary insanity.

ANS: c

24. An alcoholic is someone
    (a) who drinks every day.
    (b) who does poor work.
    (c) who reeks of alcohol.
    (d) may be assigned to your work center.

ANS: d

25. If treated, an alcoholic
    (a) must always be watched.
    (b) may lead a productive life.
    (c) must never be allowed to attend command functions where alcohol will be served.
    (d) may never regain your trust.

ANS: b

26. All alcoholics
    (a) should be afforded treatment.
    (b) drink every day.
    (c) do poor work.
    (d) are always late and argumentative.

ANS: a

27. Alcoholism
    (a) is cured after Level III and aftercare.
    (b) can only occur in people over 40 years of age.
    (c) is chronic, progressive and fatal if not treated.
    (d) can be caught by drinking too much.

ANS: c

28. Alcoholics
    (a) must drink every day.
    (b) can go some periods of time without a drink.
    (c) drink only "hard liquor."
    (d) all drink much more than I do.

ANS: b

29. Blackouts are
    (a) almost always longer than 2 days.
    (b) found only in late stage alcoholism.
    (c) fainting spells.
    (d) periods of time when a person cannot remember what he/she did.

ANS: d

30. Alcoholism is a disease that
    (a) affects the family and friends, too.
    (b) must not be tolerated by anyone.
    (c) makes people do bad things.
    (d) is curable.

ANS: a

31. Sons of alcoholic fathers
    (a) can never drink at all.
    (b) should not be allowed in the Navy.
    (c) are at risk for becoming alcoholics.
    (d) should be placed on Antabuse.

ANS: c

32. Non-alcoholics
    (a) can have alcohol incidents.
    (b) should never go to an AA meeting.
    (c) never have to worry about how much they drink.
    (d) should never go to PREVENT.

ANS: a

33. Alcoholics may
    (a) drink alone or hide the evidence of drinking.
    (b) become irritated when anyone questions their drinking.
    (c) feel guilty about drinking.
    (d) all of the above.

ANS: d

34. It's OK to drink too much
    (a) if you are not the Designated Driver.
    (b) you are with a group of good people.
    (c) never.
    (d) you don't drive.

ANS: c

35. Alcoholics
    (a) can be treated but never cured.
    (b) are not responsible for their behavior.
    (c) always have red noses and slurred speech.
    (d) should not be in the Navy.

ANS: a

36. An alcohol abuser
    (a) should be sent to Level III treatment.
    (b) can be taught/made to not abuse.
    (c) should never drink again.
    (d) is not responsible for his or her actions.

ANS: b

37. The Navy encourages recovering alcoholics to attend AA meetings because
(a) they can be found almost everywhere.
(b) they're free.
(c) they work.
(d) all of the above.

ANS: d

38. Fetal Alcohol Syndrome
(a) is the most preventable form of mental retardation.
(b) happens only to babies of alcoholic women.
(c) means the baby will be born an alcoholic.
(d) can't occur if a pregnant woman only drinks beer.

ANS: a

39. Women "cannot hold their liquor" as well as men because
(a) they tend to drink more potent fancy cocktails.
(b) they have smaller livers.
(c) they have less alcohol dehydrogenase than men.
(d) they have more fatty tissues than men.

ANS: c

40. The number of high school seniors who have ever used alcohol
(a) shows a slight decline since 1975.
(b) drink more now than ever because of beer commercials.
(c) drink only socially--never to get drunk.
(d) report they always have difficulty buying it because of State-imposed laws.

ANS: a

41. The results of the 1992 DOD Worldwide Survey shows
(a) over 60% of Navy members are heavy drinkers.
(b) over 60% of Navy members never drink.
(c) that 2% of Navy members never drink.
(d) that almost 14% of Navy members are heavy drinkers.

ANS: d

42. According to the 1992 DOD Worldwide Survey, the average daily amount of alcohol consumed by Navy men and women
(a) is about four shots per person.
(b) has declined since 1982.
(c) has increased a little since 1982.
(d) has doubled since 1982.

ANS: b

43. The 1992 DOD Worldwide Survey shows
    (a) E1s-E4s had the highest rate of serious consequences from drinking.
    (b) E5s-E9s had the highest rate of serious consequences from drinking.
    (c) Officers had the highest rate of serious consequences from drinking.
    (d) Rating or rank did not play a factor.

ANS: a

44. The 1992 DOD Worldwide Survey showed that military personnel
    (a) drink far less than their civilian counterparts.
    (b) drink more heavily than their civilian counterparts.
    (c) drink at the same rate as their civilian counterparts.
    (d) drink less beer than their civilian counterparts.

ANS: b

45. Amphetamines
    (a) have never had a legal medical use.
    (b) are routinely prescribed by Navy doctors for weight lose.
    (c) used to be used to keep soldiers alert during combat
    (d) cannot be detected in urine.

ANS: c

46. Amphetamines are a
    (a) non-addicting drug.
    (b) stimulant.
    (c) harmless method of dieting.
    (d) drug whose popularity has declined since cocaine became available.

ANS: b

47. The effects of amphetamines
    (a) are felt for 15-20 minutes.
    (b) put most people to sleep.
    (c) are felt for 4-6 hours.
    (d) cause extremely bizarre behavior.

ANS: c

48. "Ice"
    (a) is a powerful, crystallized form of methamphetamine.
    (b) is available only in Hawaii.
    (c) cannot be detected through urinalysis.
    (d) use among Navy members has greatly increased in the last two years.

ANS: a

49. Anabolic steroids
    (a) are non-addicting.
    (b) are used only by power lifters.
    (c) are routinely prescribed by doctors.
    (d) are on the Schedule of Controlled Drugs.

ANS: d

50. Anabolic steroid users
    (a) can be identified by their huge muscles.
    (b) exhibit severe acne and breast development in men.
    (c) cannot be prosecuted because there are medical uses for the drug.
    (d) are generally mellow and calm.

ANS: b

51. Anabolic steroid users are at risk for AIDS because
    (a) lots of homosexuals frequent gyms.
    (b) they inject the drug.
    (c) the drug is made from blood products.
    (d) the drug increases their sex drive.

ANS: b

52. Antabuse, a drug that causes a reaction when alcohol is consumed
    (a) is widely used by the Navy.
    (b) is dispensed by the DAPA.
    (c) can be ordered by an E7 or above supervisor.
    (d) can only be prescribed by a doctor.

ANS: d

53. Most States consider a person too intoxicated to drive when his or her Blood Alcohol Concentration (BAC)
    (a) reaches .10%.
    (b) reaches .05%.
    (c) can be detected by a breath analyzer.
    (d) reaches .15%.

ANS: a

54. A person can be sufficiently impaired to be a danger behind the wheel
(a) even though they think they are fine.
(b) even though they don't look drunk.
(c) with a .08% BAC.
(d) all of the above.

ANS: d

55. Caffeine is
(a) non-addicting.
(b) found only in coffee.
(c) a stimulant drug.
(d) often prescribed for ulcer patients.

ANS: c

56. Cocaine
(a) cannot be identified in urine.
(b) was once an ingredient in Coca Cola.
(c) is a depressant.
(d) is used today to alleviate withdrawal from alcohol.

ANS: b

57. "Freebasing" cocaine
(a) is time consuming and dangerous.
(b) lowers the euphoric "rush."
(c) continues to be the preferred method of ingestion.
(d) takes the addicting properties out of the drug.

ANS: a

58. Cocaine
(a) is only used by rich "Yuppies."
(b) is very expensive because of its purity.
(c) is not addicting if only small amounts are used.
(d) disrupts the central nervous system.

ANS: d

59. Cocaine users
(a) appear very mellow and calm.
(b) are often very talkative.
(c) experience a high for up to 12 hours from one dose.
(d) cannot be treated successfully.

ANS: b

60. Crack
(a) is made by mixing cocaine and heroin.
(b) is smoked only by inner-city poor people.
(c) use delays the "high" for 20-30 minutes.
(d) is cocaine.

ANS: d

61. "Crack babies"
(a) suffer no long-term effects.
(b) cannot live more than one year.
(c) can be caused by the father smoking crack.
(d) are a rarity.

ANS: c

62. Results from the 1992 DOD Worldwide Survey show
(a) declining use of cocaine by Navy members.
(b) increasing use of cocaine by Navy members.
(c) that cocaine has never been a problem for the Navy.
(d) that Navy women are more likely to use cocaine than Navy men.

ANS: a

63. Combining alcohol and prescription or over-the-counter drugs
(a) is OK if the Medical Officer prescribes them.
(b) can be a fatal combination.
(c) is OK as long as the drug is a stimulant.
(d) will always increase the benefit of the drug.

ANS: b

64. Combining alcohol and diuretics
(a) reduces blood pressure.
(b) increases fluid removal.
(c) greatly enhances the effects of cranberry juice.
(d) is not dangerous if one only drinks beer.

ANS: a

65. All Navy members who attend Level III treatment for compulsive overeating/chronic obesity
(a) are returned to the command within body fat standards.
(b) are put on strict diets.
(c) must exercise for at least two hours per day.
(d) are placed in a one-year monitored aftercare status.

ANS: d

66. To be offered Level III treatment for compulsive overeating/chronic obesity a Navy member
(a) must have completed Levels I and II.
(b) must be diagnosed by a Medical Officer.
(c) must be at least 25 pounds overweight.
(d) must sign a contract to remain in the Navy for 4 more years.

ANS: b

67. The most effective treatment for alcoholism is
(a) blood exchange.
(b) abstinence.
(c) Antabuse.
(d) Discipline.

ANS: b

68. Navy treatment for alcoholism is
(a) authorized by the CO.
(b) not cost-effective.
(c) directed by the Medical Officer.
(d) only offered after two or more incidents.

ANS: a

69. Civilian employees of the Department of the Navy
(a) fall under the regulations of OPNAVINST 5350.4 series.
(b) may be fired for being drunk on duty.
(c) cannot be disciplined for illegal drug use.
(d) can be treated at a Naval Alcohol Rehabilitation Center/Department if they have worked for the Navy for more than 10 years.

ANS: b

70. The program by which a civilian employee of the Department of the Navy self-identifies for drug abuse
(a) is called Voluntary Self Referral.
(b) does not exist.
(c) ensures job security until retirement.
(d) is called Safe Haven.

ANS: d

71. Civilians employed by the Department of the Navy
    (a) are subject to random urinalysis the same as uniformed members.
    (b) are never subject to urinalysis.
    (c) are selected for urinalysis by virtue of the position they hold.
    (d) are subject to urinalysis only when they are hired.

ANS: c

72. Civilian employees of the Department of the Navy may be subject to random urinalysis if they have completed drug or alcohol treatment within
    (a) the last year.
    (b) the last five years.
    (c) ever since being hired.
    (d) the last two years and are found possessing illegal drugs off duty.

ANS: a

73. Department of the Navy civilians are subject to direct observation
    (a) only when the Office of Civilian Manpower Management authorizes it.
    (b) when ordered to produce a sample after treatment.
    (c) if they have had more than one incident.
    (d) never.

ANS: b

74. When a Department of the Navy civilian has a positive urinalysis test
    (a) he or she is immediately fired.
    (b) he or she may not be disciplined.
    (c) he or she may produce a prescription from a civilian doctor.
    (d) his or her supervisor may order the person into treatment.

ANS: c

75. Results of a DON civilian positive urinalysis are sent to
    (a) the CO.
    (b) the DAPA.
    (c) the Medical Review Officer.
    (d) The Office of Civilian Manpower Management.

ANS: c

76. It is estimated that an alcohol-related family problem strikes
(a) every other American home.
(b) one of every 20 American homes.
(c) one of every 10 American homes.
(d) one of every 4 American homes.

ANS: d

77. National surveys have shown that the approximate percentage of children of alcoholic families who marry alcoholics is
(a) 50%.
(b) 30%.
(c) 10%.
(d) 80%.

ANS: b

78. The most widely-known support group for family or friends of alcoholics
(a) is Al-Anon.
(b) is Women for Sobriety.
(c) is the Family Alcohol Education Program.
(d) is Alcoholics Anonymous.

ANS: a

79. The families of Navy alcoholics may be treated
(a) only through CHAMPUS.
(b) at Navy facilities on a space-available basis.
(c) at the Salvation Army.
(d) at Level I command programs.

ANS: b

80. Fetal alcohol birth defects are
(a) diagnosable only if the mother is an alcoholic.
(b) evident if the mother drinks in the first 3 months of pregnancy.
(c) rarely seen if the mother stops drinking in the last 3 months.
(d) the leading cause of mental retardation in America.

ANS: d

81. The quickest "high" from heroin is achieved by
(a) "mainlining" (injecting into a vein).
(b) "skinpopping" (injecting just under the skin).
(c) "muscling" (injecting into a muscle).
(d) "cooking" (combining into cooked ingredients).

ANS: a

82. The National Household Survey of Drug Abuse shows that heroin use
(a) has greatly increased since 1985.
(b) has greatly declined since 1985.
(c) has remained about the same since 1985.
(d) has virtually stopped since the Harrison Act was passed in 1985.

ANS: c

83. Because the substances making up the group of drugs known as inhalants (glue, gasoline, "laughing gas," spray paint, correction fluid, etc.)
(a) are legally purchased, the Navy does not classify their misuse as a drug incident.
(b) are widely available many youngsters use them.
(c) have a legitimate use, the Navy does not test for them.
(d) are so deadly when abused, possession is punishable under the UCMJ.

ANS: b

84. LSD is classified as
(a) a stimulant.
(b) a depressant.
(c) an hallucinogen.
(d) an upper.

ANS: c

85. LSD use by Navy members has
(a) increased.
(b) decreased.
(c) remained the same.
(d) never been identified because it does not show up in urine.

ANS: a

86. LSD is
(a) considered very dangerous because all users experience "flashbacks."
(b) virtually unfound in today's society.
(c) usually sold as a fine white powder.
(d) not considered addicting.

ANS: d

87. Today's marijuana is
(a) less potent than that of the '60's.
(b) more potent than that of the '60's.
(c) the same strength as that of the '60's.
(d) grown exclusively in Hawaii.

ANS: b

88. Marijuana
(a) is now the third leading commodity in the U.S.
(b) is grown mostly in South American countries.
(c) is produced in illegal laboratories in the U.S.
(d) is extracted from poppy flowers.

ANS: a

89. The 1980 DOD Worldwide Survey showed the following percentage of Navy members reporting the use of marijuana as:
(a) 56%.
(b) 7%.
(c) 32%.
(d) 86%.

ANS: c

90. Nicotine is considered
(a) a psychoactive drug.
(b) a non-addicting drug.
(c) to be found in only cigarettes.
(d) to be a National health epidemic.

ANS: a

91. Because tobacco products can be bought legally
(a) withdrawal symptoms are only mental.
(b) the Navy cannot regulate their use.
(c) they are considerably less dangerous than cocaine or heroin.
(d) none of the above.

ANS: d

92. The popularity of smokeless tobacco (chewing tobacco and snuff) among military members
(a) is decreasing.
(b) is about the same as in 1985.
(c) is increasing.
(d) is OK because it doesn't give off second-hand smoke.

ANS: c

93. PCP
(a) use is as prevalent as cocaine use.
(b) was used as a general anesthetic.
(c) use is found only among inner-city poor populations.
(d) is a non-addicting drug.

ANS: b

94. PCP
(a) can be sold as a liquid or powder.
(b) street doses are almost always 80% or better pure.
(c) can only be added to smokable products.
(d) cannot be identified through urinalysis.

ANS: a

95. PCP users
(a) eliminate the drug quickly through urine.
(b) may exhibit bizarre behavior.
(c) usually nod off to sleep after 20 minutes or so.
(d) always act the same when using the same amount of drug.

ANS: b

96. Use of prescription drugs
(a) is always legal because a Medical Officer must prescribe them.
(b) is considered drug abuse if taken by someone other than for whom the prescription was written.
(c) cannot be detected in urine.
(d) should be discontinued as soon as you feel better or else you may become addicted.

ANS: b

97. Because of prior bad experiences and public and professional awareness, the number of prescriptions written for psychoactive substances
(a) has greatly decreased.
(b) has ceased all together.
(c) is not allowed in the Navy.
(d) has shown no decrease.

ANS: d

98. Gambling
(a) is considered illegal in the Navy.
(b) does not affect the Navy as long as members pay their debts.
(c) can cause lowered performance or time lost from work.
(d) is prohibited onboard all Navy ships.

ANS: c

99. Gamblers
(a) gamble only to win large amounts of money.
(b) are decreasing in numbers because of legal issues.
(c) gamble only as long as they win.
(d) are considered addicted if they gamble despite adverse consequences.

ANS: d

100. The 1992 DOD Worldwide Survey showed that personnel who could be classified as potential problem gamblers is as high as
(a) 5%.
(b) 25%.
(c) 45%.
(d) 75%.

ANS: a

101. Alcoholics Anonymous -- AA -- meetings
(a) are only for treated alcoholics.
(b) may be open to anyone or closed to anyone but people with alcohol problems.
(c) require a $5 admission fee.
(d) may not be held onboard Navy ships or bases.

ANS: b

102. A Navy man or woman may attend AA meetings
(a) only with their supervisor's permission.
(b) only if they have been diagnosed as alcohol-dependent.
(c) if they believe they may have a problem with alcohol.
(d) at any time -- on or off duty.

ANS: c

103. AA groups
(a) can be found worldwide.
(b) are found only in free-world countries.
(c) refuse entry to other than alcoholics.
(d) require everyone to be sober.

ANS: a

104. AA meetings held on Navy bases
(a) are open to only DAPAs and recovering alcoholics.
(b) cannot be used by dependents.
(c) are encouraged.
(d) must be smoke free.

ANS: c

105. Which of the following is true:
(a) there is a suicidal personality or type of individual.
(b) small amounts of alcohol do not produce suicide attempts.
(c) talking about suicide increases the likelihood of it occurring.
(d) alcohol use increases the chances of a suicide attempt.

ANS: d

106. Women attempt suicide
(a) at about three times the rate of men.
(b) at about the same rate as men.
(c) at less than 1/2 the rate for men.
(d) at about 50% more than men.

ANS: a

107. If someone you know tells you they are considering suicide, you should
(a) do nothing because people who talk about it rarely do it.
(b) offer them a drink and go get the DAPA.
(c) talk about it and call for help.
(d) change the subject and report it to the Medical Officer.

ANS: c

108. Navy Drug Screening Laboratories cannot do confirmation tests for
(a) LSD.
(b) anabolic steroids.
(c) PCP.
(d) none of the above.

ANS: b

109. A positive urinalysis finding can be confirmed:
(a) by a command Port-A-Kit.
(b) by a radioimmunoassay test run by the Medical Officer.
(c) by a Navy drug lab after three tests.
(d) by the CO when he or she suspects drug use.

ANS: c

110. Navy members may be separated from the service for drug abuse
(a) if the presence of any drug is found in the urine.
(b) if the CO suspects drug abuse.
(c) if they hang out with known abusers.
(d) if the urine tests positive above a DOD cutoff level.

ANS: d

P O S T E R S/F L Y E R S

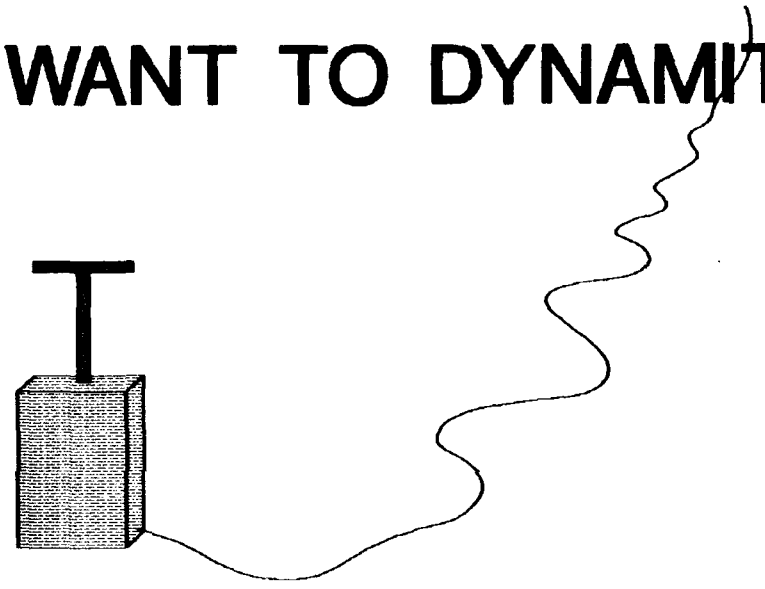
POSTERS/FLYERS/FULL-PAGE "ADS"

The following pages may be localized by inserting the DAPA's name, phone number or room/compartment number. These pages may be reproduced on colored paper and used as posters on bulletin boards in high-traffic areas (e.g., by elevators, on the quarter deck, in the military personnel support office, at the mini-mart, geedunk area, etc.). They may also be reproduced and forwarded to division heads for local work center posting or sent to the public affairs office/editor of the local newspaper or POD.

These pages were produced with Harvard Graphics on a personal computer using Draw/Annotate and Symbols. DAPAs are encouraged to "get creative" and design their own posters. Just remember -- spelling must be accurate and messages should be succinct, tasteful, and eye-appealing. If used as posters, the pages should be changed often (about every two weeks) and relevant to the audience you're trying to reach.

Another way of fostering interest in the command's alcohol and other drugs program might be the initiation of a poster contest. Judging panels might include the CO or XO, the Chaplain, the DAPA and the Command Master Chief. Prizes could be plaques, liberty, reserved parking for a month, lunch with the CO or CMC, etc. The "winning" posters should be hung in a high visibility area and announced in the POD/newspaper. Winning entries may be forwarded to the Navy Drug and Alcohol Program Division, Bureau of Naval Personnel, Pers-6341, Washington, DC 20370. Entries should include originator's rate/rank, name, command and duty address as well as the forwarding DAPA's name and telephone number (DSN and commercial). Entries will be acknowledged.

WANT TO DYNAMITE YOUR CAREER?

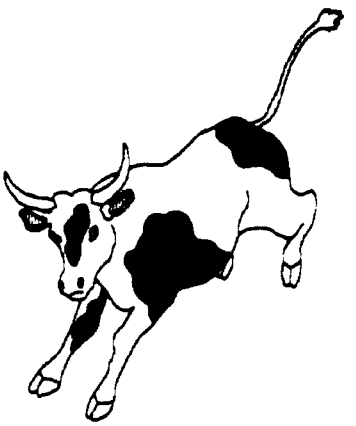


DO DRUGS!

For alcohol and other drug information,

call the DAPA on _____

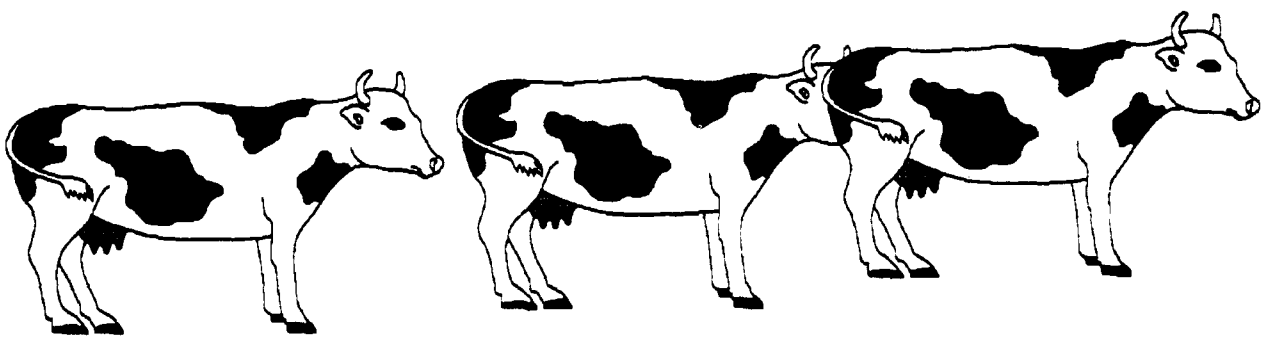
DON'T BE COWED

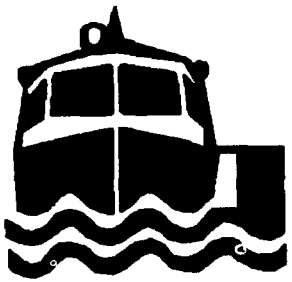


BY THE HERD . . . IT'S OK

NOT TO DRINK!

For more alcohol and other drug information, call the command DAPA at





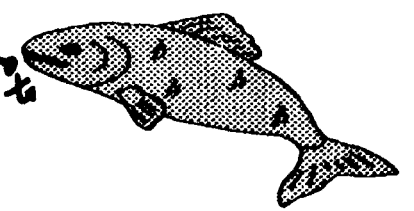
BOATING AND ALCOHOL DON'T MIX

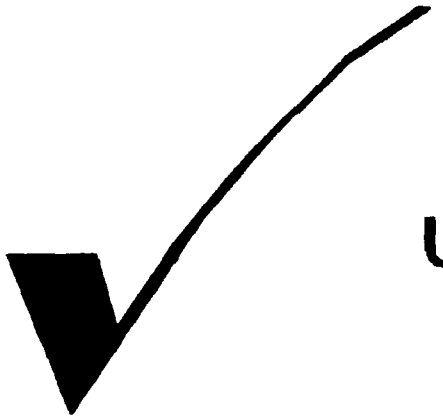
RED, RIGHT, RETURN ... SOBER

For more information,

call the command DAPA:

_____





DO YOU EVER DRINK HEAVILY WHEN YOU ARE DISAPPOINTED, UNDER PRESSURE OR HAVE HAD A QUARREL WITH SOMEONE?

CAN YOU HANDLE MORE ALCOHOL NOW THAN WHEN YOU FIRST STARTED TO DRINK?

COULD BE YOU'RE HEADED FOR TROUBLE WITH ALCOHOL!

Talk with the DAPA on _____



MISUSE OF A PRESCRIPTION

OR TAKING SOMEONE ELSE'S

MEDICINE, IS DRUG ABUSE!

For more alcohol and other drug

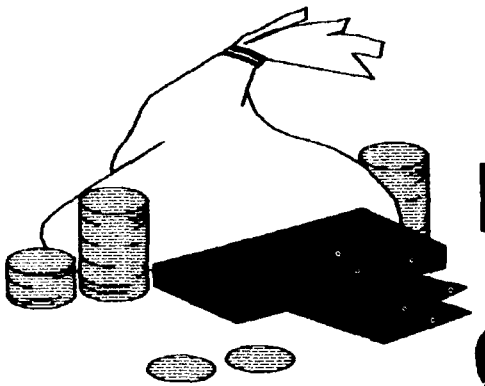
information, call the Command DAPA

on _____

ALCOHOL ABUSE COULD THROW IT ALL AWAY!



For more information about alcohol and other drugs, call the DAPA on _____



DRUNK DRIVING COULD COST YOU MORE THAN A STRIPE . . .

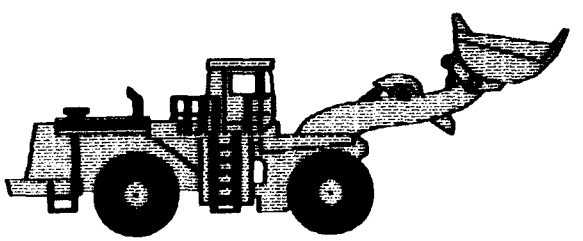
IT COULD COST YOU A CAREER!

For more alcohol and other drug information, call the Command DAPA

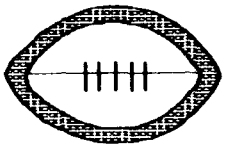


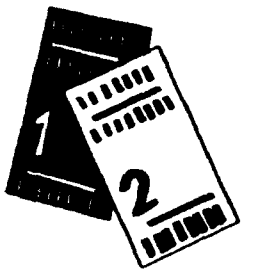
ALCOHOL IMPAIRS MOTOR SKILLS

For more alcohol and other drug information, call _____





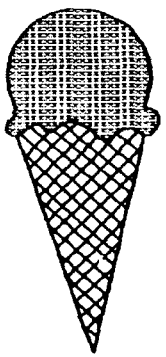


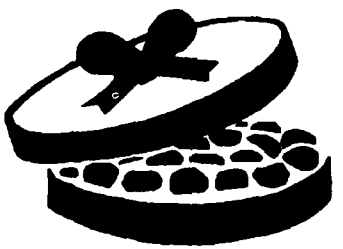


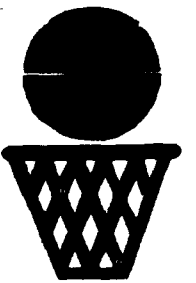
THERE'S LOTS TO DO

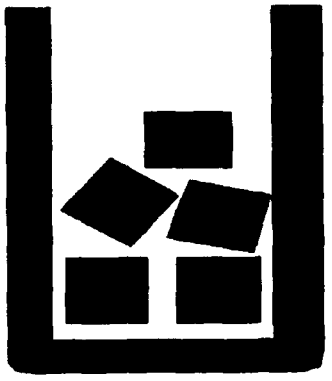
INSTEAD OF GETTING DRUNK!

For more information on alcohol and other drugs, call the DAPA on _____









IT'S NOT COOL TO GET DRUNK!

For more alcohol and other drug information, call the command DAPA at _____

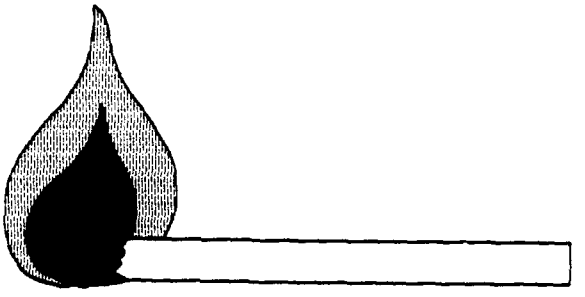


DO DRUGS AND YOU'LL BE HEADED TOWARD ROUGH SEAS!

For more alcohol and other drug information, call your Command DAPA on

_____

40% OF PEOPLE WHO DIED

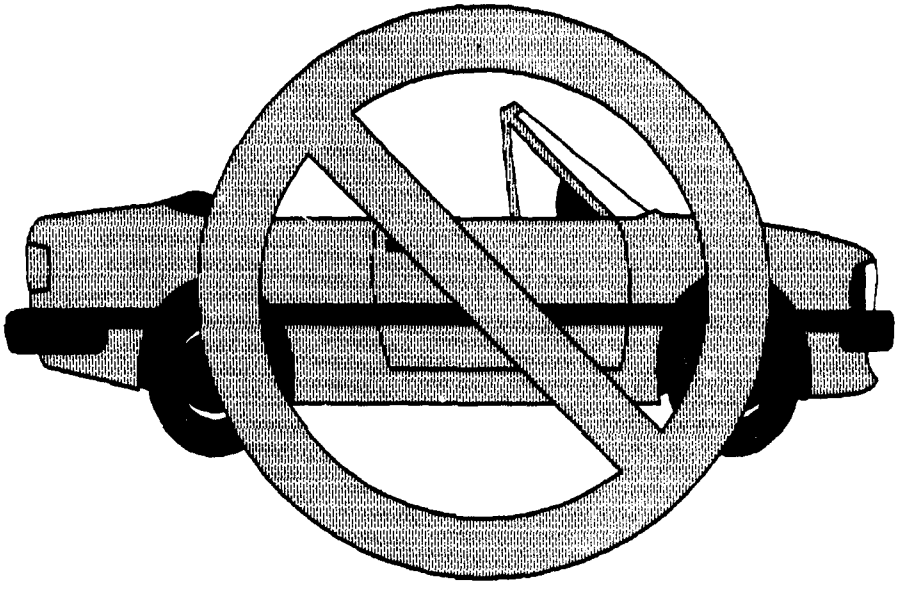


IN FIRES WERE UNDER THE INFLUENCE*

For more alcohol and other drug information, call the Command DAPA, _____

*New England Journal of Medicine, 9/92

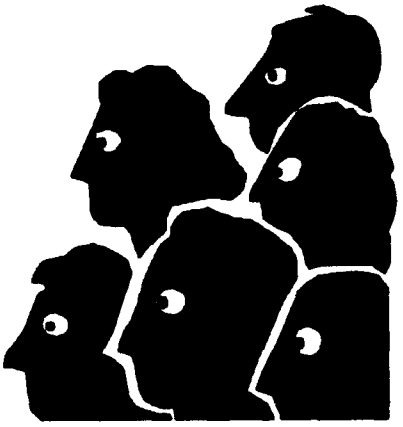
WE CAN'T AFFORD TO LOSE OUR SHIPMATES



TO ALCOHOL-RELATED CRASHES!

Command DAPA: _____

IF THERE'S ONE
IN YOUR CROWD,
TAKE THE KEYS!





FRIENDS DON'T
LET FRIENDS
DRIVE DRUNK!

FOR MORE ALCOHOL AND OTHER DRUG INFORMATION, CALL THE COMMAND DAPA, _____



WANT TO CLIMB TO THE TOP?

YOU CAN'T GET THERE DRUNK!

For more alcohol and other drug information, call your command DAPA

_____

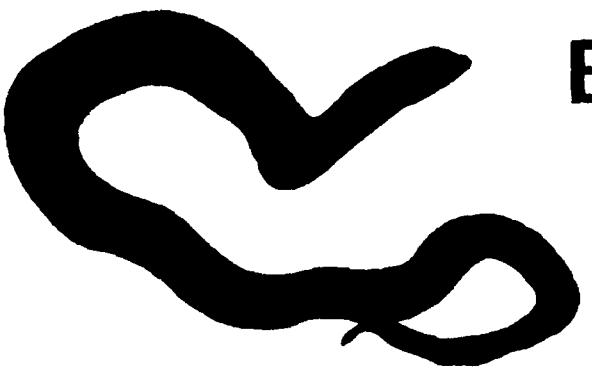


A SIMPLE CURE FOR A "BEAR" OF A HANGOVER . . .

DON'T DRINK!

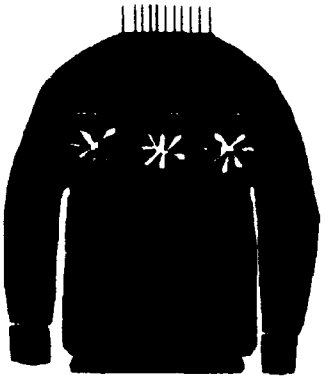
For more alcohol and other drug information, call the command DAPA _____

ALCOHOL WON'T CURE

A SNAKE  BITE . . .

Nor anything else that ails you.

For more alcohol and other drug information, call the DAPA on _____



KNOW SOMEONE WHO'S LIFE SEEMS TO BE UNRAVELING?

MAYBE THE PROBLEM IS ALCOHOL

For more alcohol and other drug information, call the Command DAPA

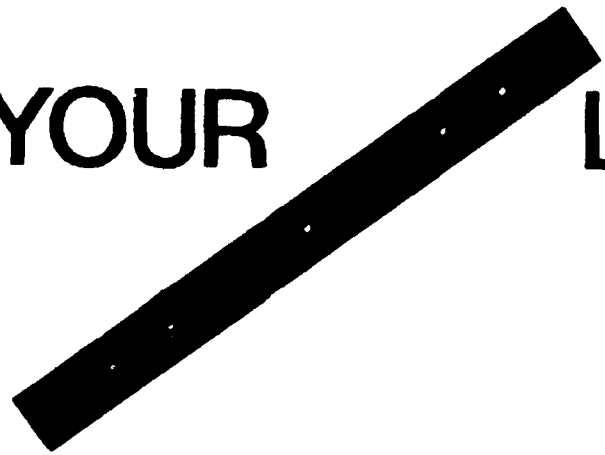
YOU'RE PUSHING YOUR LUCK



IF YOU'RE DRIVING DRUNK!

For more alcohol & other drug information, call the Command DAPA on _____

DON'T LET ALCOHOL RULE YOUR LIFE!



Talk it over with the Command DAPA, _____